General

Guideline Title

Managing chronic pain in adults with or in recovery from substance use disorders.

Bibliographic Source(s)

Substance Abuse and Mental Health Services Administration. Managing chronic pain in adults with or in recovery from substance use disorders. HHS publication no. (SMA) 12-4671. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2011. 114 p. (Treatment improvement protocol (TIP) series; no. 54).

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): The following information is taken from the section summaries. For a full discussion of the guidance and rationale, please see the original guideline document.

Patient Assessment

- Patients should receive a comprehensive initial assessment.

- It is important to discover the cause of a patient's chronic pain; however, clinicians should not assume a patient is disingenuous if the cause is not discovered.
- The patient's personal and family substance use histories and current substance use patterns should be assessed.
- It is crucial to obtain collateral information on the patient's pain level and functioning, as well as substance use disorder (SUD) status.
- Comorbid psychological disorders should be assessed and treated.
- Assessment of the patient with co-occurring chronic pain and SUD or other behavioral health disorders should be ongoing.

Chronic Pain Management

- Pain treatment goals should include improved functioning and pain reduction.
- Treatment for pain and comorbidities should be integrated.
- Non-opioid pharmacological and nonpharmacological therapies, including complementary and alternative medicine (CAM), should be considered routine before opioid treatment is initiated.
- Opioids may be necessary and should not be ruled out based on an individual's having an SUD history.
- The decision to treat pain with opioids should be based on a careful consideration of benefits and risks.
- Addiction specialists should be part of the treatment team and should be consulted in the development of the pain treatment plan, when possible.
- A substantial percentage of patients with and without SUDs will fail to benefit from prolonged opioid therapy, in which case it should be discontinued, as with any other failed treatment.

Managing Addiction Risk in Patients Treated with Opioids

- Patients on chronic opioid therapy should be monitored closely for signs of benefit, harm, and aberrant drug-related behaviors (ADRBs).
- All ADRBs should be documented, investigated, and acted on.
- Difficult conversations should be managed with compassion and empathy.
- Clinicians should establish and respectfully maintain strict limits with patients who insist on opioids.
- Clinicians should establish relationships with drug-testing laboratory staff and addiction specialists.
- When it is necessary to discontinue chronic opioid therapy, a conscientious tapering plan should be provided.

Patient Education and Treatment Agreements

- Patient education is necessary for informed consent, and it equips patients to take an active role in their pain management.
- Education must be tailored to the individual patient. More research is needed on tailoring education to patients who have chronic noncancer pain (CNCP).
- Clinicians should take time to educate their patients and make sure patients understand how to help themselves.
- People learn in different ways; clinicians should have a variety of learning materials at their disposal.
- Treatment agreements document the treatment plan and the responsibilities of the patient and the clinician.

Clinical Algorithm(s)

The following algorithms are provided in the original guideline document:

- Managing Chronic Pain in Patients with SUD
- Exit Strategy

Scope

Disease/Condition(s)

Chronic noncancer pain (CNCP) associated with conditions such as sickle cell disease, backache, fibromyalgia, recurrent pancreatitis, and HIV

Other Disease/Condition(s) Addressed

- Anxiety

- Depression
- Post traumatic stress disorder (PTSD)
- Somatoform disorders
- Substance-related disorders

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Screening

Treatment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Nursing

Pharmacology

Physical Medicine and Rehabilitation

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Health Care Providers

Health Plans

Hospitals

Managed Care Organizations

Nurses

Pharmacists

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

To equip clinicians with practical guidance and tools for treating chronic noncancer pain (CNCP) in adults with histories of substance use disorders (SUDs)

Note: This guideline does not describe how to treat SUDs or other behavioral health disorders in patients with CNCP; however, it provides readers with information about SUD assessments and referrals for further evaluation.

Target Population

Adults in the United States with histories of substance use disorders (SUDs) who are suffering from chronic noncancer pain (CNCP), including patients with sickle cell disease (SCD) and human immunodeficiency virus (HIV)

Interventions and Practices Considered

Diagnosis/Evaluation

1. Comprehensive initial assessment (history and physical evaluation, including individual and family history of substance abuse disease [SUD], mental status, diagnosis of source of pain, if possible)
2. Screening for SUD
3. Assessment of pain level and functioning
4. Assessment of psychiatric comorbid conditions
5. Ongoing reassessment

Management/Treatment

1. Development of a pain treatment plan
2. Integration of pain and comorbidity treatment
3. Initial treatment with non-opioid and nonpharmacological methods, including complementary and alternative medicines (CAMs)
4. Treatment with opioids following careful risk/benefit analysis
5. Addition of an addiction treatment specialist to the care team
6. Tapering and discontinuation of opioid or other failing treatment
7. Monitoring for and management of aberrant drug-related behavior (ADRB)
8. Establishing relationships with drug testing laboratory staff and addiction specialists

Counseling

1. Use of an empathetic demeanor
2. Obtaining informed consent
3. Encouraging active patient role in pain management
4. Provision of information over time and in a variety of ways
5. Use of treatment agreement documents between patients and physicians

Major Outcomes Considered

- Sensitivity, specificity and validity of assessment and screening tools
- Prevalence of problems associated with chronic opioid therapy (addiction, dependence, abuse, aberrant drug-related behaviors, misuse)
- Pain relief
- Pain relapse

- Rate of referral to inpatient programs
- Rate of medication adherence
- Development of medication tolerance
- Adverse effects of medications

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Starting in September 2007, professional librarians from the Center for Substance Abuse Research (CESAR) at the University of Maryland conducted a series of searches to locate literature that discussed both chronic noncancer pain (CNCP) and substance use disorders (SUDs) as it pertained to topics relevant to this Treatment Improvement Protocol (TIP). The TIP's major topics are:

- Patient assessment
- Pain management
- Patient education
- Monitoring adherence/aberrant drug-related behaviors

Special topics included:

- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Acute pain/perioperative pain
- Marijuana in the treatment of chronic pain
- Patients on medication for opioid use disorders

The TIP was not developed to advise clinicians on how to treat the many individual types of CNCP such as low back pain, neck pain, fibromyalgia, or migraines. Instead, evidence was sought that would be relevant to a clinician who may treat any type of chronic pain in patients with a history of SUDs. The literature search was complex because, in most databases used, much of the information was not indexed in a way that facilitated the search.

The following databases were searched:

- PubMed
- PsycINFO
- SocINDEX
- Academic Search Premier

Initially, searches were limited to publications in English from 2001 to 2007, involving human subjects. In general, searches combined the concepts of "chronic pain" OR "chronic noncancer pain" AND "substance use disorder" OR "SUD" "addiction" OR "substance abuse" with topical search terms. Search terms were tailored to particular databases. For example, to search PubMed for articles about comorbid conditions in the target patient, the following strategy was used:

- Apply limits.
- Combine pain [medical subject heading (MeSH)] serially with dual diagnosis [MeSH] and comorbidity.
- Combine substance-related disorders [MeSH] OR substance abuse treatment centers [MeSH] AND pain [MeSH]. Combine result serially with depression [MeSH], anxiety [MeSH], somatoform disorders [MeSH], physical deconditioning [text], stress disorders, post-traumatic [MeSH], sleep disorders [MeSH], cognition disorders [MeSH], mental disorders [MeSH].

Returns were reviewed carefully first by CESAR librarians for relevance, and abstracts of items found relevant were sent to JBS International, Inc., for further culling. Because the experience and expression of pain are mediated in part by culture, research on non-U.S. subjects was eliminated with few exceptions made for studies with no U.S. equivalents. Articles that focused on treating SUDs as opposed to treating CNCP were also eliminated as beyond the scope of the TIP.

The searches were updated periodically while the TIP was in development using the search terms: chronic pain, pain management, chronic noncancer pain, chronic nonmalignant pain, pain patient, pain intervention and recovery, substance use disorder or substance abuse, opioid or prescription drug abuse. Several additional searches were performed throughout 2011, with the last one before publication occurring in December of 2011.

In addition to the articles located by the electronic searches, some articles were retrieved because they were recommended by consensus panelists or were identified through references in the articles previously consulted.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Treatment Improvement Protocol (TIP) Development Process

TIP topics are based on the current needs of behavioral healthcare professionals and other medical care practitioners for information and guidance. After selecting a topic, Substance Abuse and Mental Health Services Administration (SAMHSA) invites staff members from Federal agencies and national organizations to be members of a resource panel that reviews an initial draft prospectus and outline and recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. These recommendations are communicated to a consensus panel composed of experts on the topic who have been nominated by their peers. In partnership with Knowledge Application Program writers, consensus panel members participate in creating a draft document and then meet to review and discuss the draft. The information and recommendations on which they reach consensus form the foundation of the TIP. The panel Chair ensures that the guidelines mirror the results of the group's collaboration.

The literature review (see the "Availability of Companion Documents" field) presents the evidence on which the TIP's recommendations are based. Where sufficient evidence does not exist, the TIP is based on the clinical experience and judgment of the TIP's consensus panel of experts.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Description of Method of Guideline Validation

A diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the treatment improvement protocol (TIP) is prepared for publication, in print and online (http://www.kap.samhsa.gov/).

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The literature review (see the "Availability of Companion Documents" field) presents the evidence on which the treatment improvement protocol's (TIP) recommendations are based. Where sufficient evidence does not exist, the TIP is based on the clinical experience and judgment of the TIP's consensus panel of experts.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of chronic pain in adults with or in recovery from substance use disorders

Potential Harms

Adverse Effects of Non-opioid Medications

- Nonsteroidal anti-inflammatory drugs (NSAIDs) may cause gastrointestinal bleeding and renal insufficiency.
- Tricyclic antidepressants may be associated with anticholinergic side effects and orthostatic hypotension (fall risk in older people).
- Antipsychotics can cause extrapyramidal reactions and metabolic syndrome.

Adverse Effects of Opioids

- Opioids have limitations, such as diminished efficacy over time. Opioids also have adverse effects that many patients cannot tolerate (e.g., nausea, sedation, constipation). Other drawbacks include risk of addiction or addiction relapse, opioid-induced hyperalgesia (OIH), and many potential drug interactions.

- Serotonin syndrome can cause agitation, confusion, fever, and seizures, and it can be lethal if undetected or untreated. Patients who take selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), St. John's wort, monoamine oxidase inhibitors, lithium, or human immunodeficiency virus (HIV) medications are at increased risk of serotonin syndrome. In addition, patients who take opioids chronically are at increased risk of serotonin syndrome if medications such as fentanyl, meperidine, or pentazocine are needed in emergency or surgical care settings.

Adverse Effects of Drugs Used in Medication-Assisted Recovery

- Buprenorphine can induce acute opioid withdrawal.
- Methadone is especially toxic because of issues of accumulation, drug interaction, and QT prolongation. For these reasons, it should be prescribed only by providers who are thoroughly familiar with it. Patients starting methadone should receive a thorough education in the dangers of inadvertent overdose with this medication. It is critical for the clinician to advise patients to stop methadone treatment if they become sedated.
- Patients taking naltrexone should not be prescribed outpatient opioids for any reason. Because naltrexone displaces opioid agonists from their binding sites, opioid analgesics will not be effective in patients on naltrexone. Increasing the dose of opioids to overcome the blockade puts the patient at risk of respiratory arrest. If patients on naltrexone require emergency opioids for acute pain, higher doses are required, which, if continued, can become toxic as naltrexone levels wane. In this situation, inpatient or prolonged emergency department monitoring is required.

Urine Drug Testing (UDT)

UDT is subject to false-positive and false-negative results.

Contraindications

Contraindications

- Patients taking naltrexone should not be prescribed outpatient opioids for any reason.
- Patients who are dependent on opioids or sedatives (including benzodiazepines) should not be withdrawn from these medications while undergoing acute medical interventions.
- If the patient declines to give consent, prolonged treatment with controlled substances may be contraindicated.

Qualifying Statements

Qualifying Statements

- The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of Substance Abuse and Mental Health Services Administration (SAMHSA) or U.S. Department of Health and Human Services (HHS).
- Although each consensus-based Treatment Improvement Protocol (TIP) strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.
- The TIP was not developed to advise clinicians on how to treat the many individual types of chronic noncancer pain (CNCP) such as low back pain, neck pain, fibromyalgia, or migraines. Instead, evidence was sought that would be relevant to a clinician who may treat any type of chronic pain in patients with a history of substance use disorders (SUDs).

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Substance Abuse and Mental Health Services Administration. Managing chronic pain in adults with or in recovery from substance use disorders. HHS publication no. (SMA) 12-4671. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2011. 114 p. (Treatment improvement protocol (TIP) series; no. 54).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011

Guideline Developer(s)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

Source(s) of Funding

United States Government

Guideline Committee

Consensus Panel

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site .

Availability of Companion Documents

The following is available:

- Managing chronic pain in people with or in recovery from substance use disorders. A review of the literature. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2012 Jan. 71 p. Electronic copies: Available in Portable Document Format (PDF) from the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site .

In addition, the Screener and Opioid Assessment for Patients with Pain–Revised (SOAPP–R) and the Opioid Risk Tool (ORT), a sample consent form, an addiction behaviors checklist, the Current Opioid Misuse Measure, and a sample pain treatment agreement are available in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on August 21, 2012. The information was verified by the guideline developer on August 30, 2012. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

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